

EXHIBIT B



EmblemHealth® City of New York CBP Basic Program

Summary of Benefits and Coverage: What this Plan Covers & What it Costs | Coverage for: Individual/Family | Plan Type: PPO

Coverage Period: 7/1/2013 - 6/30/2014



This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.emblemhealth.com or by calling 1-800-624-2414.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	\$200 individual/\$500 family for out-of-network only.	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible .
Are there other deductibles for specific services?	Yes	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
Is there an out-of-pocket limit on my expenses?	No	Not applicable because there's no out-of-pocket limit on your expenses.
What is not included in the out-of-pocket limit?	Co-payments, premiums, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .
Is there an overall annual limit on what the plan pays?	No	The chart starting on page 2 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.
Does this plan use a network of providers?	Yes. See www.EmblemHealth.com or call 1-877-842-3625 for a list of participating providers.	If you use an in-network doctor or other health care provider , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred , or participating for providers in their network . See the chart starting on page 2 for how this plan pays different kinds of providers .
Do I need a referral to see a specialist?	No	You can see the specialist you choose without permission from this plan
Are there services this plan doesn't cover?	Yes	Some of the services this plan doesn't cover are listed on page 4. See your policy or plan document for additional information about excluded services .

Questions: Call 1-800-624-2414 or visit us at www.emblemhealth.com/sbc.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.emblemhealth.com/sbc or call 1-800-624-2414 to request a copy.



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Summary of Benefits and Coverage: What this Plan Covers & What it Costs

- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is your share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$15 co-pay	0% co-insurance	---None---
	Specialist visit	\$20 co-pay	0% co-insurance	Does not apply to all specialists.
	Other practitioner office visit	\$15 co-pay	0% co-insurance	---None---
	Preventive care/screening/immunization	\$15 co-pay	0% co-insurance	---None---
If you have a test	Diagnostic test (x-ray, blood work)	\$15 co-pay	0% co-insurance	---None---
	Imaging (CT/PET scans, MRIs)	\$15 co-pay	0% co-insurance	Pre-certification required.
If you need drugs to treat your illness or condition	Generic drugs	Not covered	Not covered	---None---
	Preferred brand drugs	Not covered	Not covered	---None---
	Non-preferred brand drugs	Not covered	Not covered	---None---
	Specialty drugs	Not covered	Not covered	---None---
More information about prescription drug coverage is available at www.EmblemHealth.com .				

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EmblemHealth® City of New York CBP Basic Program **Summary of Benefits and Coverage: What this Plan Covers & What it Costs**

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Coverage for: Individual/Family | **Plan Type:** PPO

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Not covered	Not covered	Please check with your employer.
	Physician/surgeon fees	Covered	0% co-insurance	---None---
	Emergency room services	Not covered	Not covered	---None---
If you need immediate medical attention	Emergency medical transportation	Not covered	20% co-insurance	---None---
	Urgent care	\$15 co-pay	0% co-insurance	---None---
If you have a hospital stay	Facility fee (e.g., hospital room)	Not covered	Not covered	---None---
	Physician/surgeon fee	Covered	0% co-insurance	---None---
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	\$15 co-pay	Subject to New York City non-participating benefit \$200/\$500 calendar year deductible	No lifetime maximum
	Mental/Behavioral health inpatient services	\$300 co-pay per admission	\$500 co-pay per admission/\$1250 maximum per calendar year	20% to max of \$2,000 per person per calendar year
	Substance use disorder outpatient services	\$15 co-pay	Subject to New York City non-participating benefit \$200/\$500 calendar year deductible	No lifetime maximum
	Substance use disorder inpatient services	\$300 co-pay per admission	\$500 co-pay per admission/\$1250 maximum per calendar year	---None---
If you are pregnant	Prenatal and postnatal care	No charge	0% co-insurance	---None---
	Delivery and all inpatient services	No charge	0% co-insurance	---None---

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Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	No charge	\$50 deductible per episode; 20% co-insurance	200 visits per member per year. Pre-certification required.
	Rehabilitation services	\$15 co-pay	0% co-insurance	
	Habilitation services	\$15 co-pay	0% co-insurance	16 visits per calendar year
	Skilled nursing care	Not covered	Not covered	None----
	Durable medical equipment	\$100 deductible	\$100 deductible; 50% of usual and customary charge	Pre-certification required on greater than \$2,000
If your child needs dental or eye care	Hospice service	Not covered	Not covered	None----
	Eye exam	Not covered	Not covered	None----
	Glasses	Not covered	Not covered	None----
	Dental check-up	Not covered	Not covered	None----

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)	
<ul style="list-style-type: none"> • Acupuncture • Cosmetic surgery • Dental care 	<ul style="list-style-type: none"> • Routine eye care • Routine foot care • Weight loss programs
Benefits paid as a result of injuries caused by another party may need to be repaid to the health plan or paid for by another party under certain circumstances.	
Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)	
<ul style="list-style-type: none"> • Bariatric surgery • Chiropractic care 	<ul style="list-style-type: none"> • Infertility treatment • Non-emergency care when traveling outside the U.S. • Private-duty nursing

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Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 7/1/2013 - 6/30/2014

Coverage for: Individual/Family | Plan Type: PPO

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact EmblemHealth at 1-800-624-2414. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.ccio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact EmblemHealth.

All hospital grievances should be mailed to:

EmblemHealth-Hospital Grievance
P.O. Box 2828

New York, New York 10116-2828

All other grievances should be mailed to:

EmblemHealth-Grievance Unit

P.O. Box 1701

New York, New York 10023-9476

Oral Utilization Review Appeals can be initiated by calling toll free 888-906-7668.

Or you may submit a written appeal to:

EmblemHealth Utilization Review Appeals

P.O. Box 2809

New York, NY 10116-2809

You may also obtain an external appeal application from:

The New York State Department of Financial Services at 1-800-400-8882, or its

Web site (www.dfs.ny.gov), or

The EmblemHealth Medical/Utilization Review Department at 1-877-482-3625

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-624-2414.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-624-2414.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-624-2414.

Navajo (Dine): Dinekehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-624-2414

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

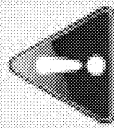
Questions: Call **1-800-624-2414** or visit us at **www.emblemhealth.com/sbc**.

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About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



**This is
not a cost
estimator.**

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby (normal delivery)

- Amount owed to providers: \$7,540
- Plan pays \$7315
- Patient pays \$225

Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
Total	\$7,540

Patient pays:

Deductibles	\$0
Co-pays	\$75
Co-insurance	\$0
Limits or exclusions	\$150
Total	\$225

Note: These numbers assume the patient has given notice of her pregnancy to the plan. If you are pregnant and have not given notice of your pregnancy, your costs may be higher. For more information, please contact: 1-800-624-2414.

Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- Amount owed to providers: \$5,400
- Plan pays 4125.47
- Patient pays 1274.53

Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
Total	\$5,400

Patient pays:

Deductibles	\$0
Co-pays	\$535
Co-insurance	0
Limits or exclusions	\$739.53
Total	1274.53

Note: These numbers assume the patient is participating in our diabetes wellness program. If you have diabetes and do not participate in the wellness program, your costs may be higher. For more information about the diabetes wellness program, please contact: 1-800-624-2414.



Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, co-payments, and co-insurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

- ✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

- ✗ **No.** Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

- ✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

- ✓ **Yes.** An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as co-payments, deductibles, and co-insurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.



EmblemHealth® City of New York CBP w/ Opt. Rider

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Important Questions	Answers	Why this Matters:
What is the overall deductible?	\$200 individual/\$500 family for out-of-network only.	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible .
Are there other deductibles for specific services?	Yes	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
Is there an <u>out-of-pocket</u> limit on my expenses?	No	Not applicable because there's no out-of-pocket limit on your expenses.
What is not included in the <u>out-of-pocket limit</u>?	Co-payments, premiums, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .
Is there an overall annual limit on what the plan pays?	No	The chart starting on page 2 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.
Does this plan use a <u>network of providers</u>?	Yes. See www.EmblemHealth.com or call 1-877-842-3625 for a list of participating providers.	If you use an in-network doctor or other health care provider , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred , or participating for providers in their network . See the chart starting on page 2 for how this plan pays different kinds of providers .
Do I need a referral to see a <u>specialist</u>?	No	You can see the specialist you choose without permission from this plan
Are there services this plan doesn't cover?	Yes	Some of the services this plan doesn't cover are listed on page 4. See your policy or plan document for additional information about excluded services .

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- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is your share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your deductible.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$15 co-pay	0% co-insurance	----None----
	Specialist visit	\$20 co-pay	0% co-insurance	Does not apply to all specialists.
	Other practitioner office visit	\$15 co-pay	0% co-insurance	----None----
	Preventive care/screening/immunization	\$15 co-pay	0% co-insurance	----None----
If you have a test	Diagnostic test (x-ray, blood work)	\$15 co-pay	0% co-insurance	----None----
	Imaging (CT/PET scans, MRIs)	\$15 co-pay	0% co-insurance	Pre-certification required.

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Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
<p>If you need drugs to treat your illness or condition</p> <p>More information about prescription drug coverage is available at www.EmblemHealth.com.</p>	Generic drugs	Retail-30 days supply-2 fills; Deductible \$150 ind/\$450 fam; 20% co-insurance with min charge of \$5 or actual cost if less	Not covered	Mandatory mail order - 60 day supply; \$10 co-pay. Prescriptions will not be filled at retail after 2 fills.
	Preferred brand drugs	Retail-30 days supply-2 fills; Deductible \$150 ind/\$450 fam; 40% co-insurance with min charge of \$25 or actual cost if less	Not covered	Mandatory mail order - 60 day supply; \$40 co-pay. Prescriptions will not be filled at retail after 2 fills. Prior-authorization is required for certain brand name medications.
	Non-preferred brand drugs	Retail-30 days supply-2 fills; Deductible \$150 ind/\$450 fam; 50% co-insurance with min charge of \$40 or actual cost if less	Not covered	Mandatory mail order - 60 day supply; \$60 co-pay. Prescriptions will not be filled at retail after 2 fills.
	Specialty drugs	Covered	Not covered	Must be dispensed by the Specialty Pharmacy Program Provider.
	Facility fee (e.g., ambulatory surgery center)	Not covered	Not covered	---None---
<p>If you have outpatient surgery</p>	Physician/surgeon fees	Covered	0% co-insurance	---None---
	Emergency room services	Not covered	Not covered	---None---
	Emergency medical transportation	Not covered	20% co-insurance	---None---
<p>If you need immediate medical attention</p>	Urgent care	\$15 co-pay	0% co-insurance	---None---
	Facility fee (e.g., hospital room)	Not covered	Not covered	---None---
	Physician/surgeon fee	Covered	0% co-insurance	---None---

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Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	\$15 co-pay	Subject to New York City non-participating benefit \$200/\$500 calendar year deductible	No lifetime maximum
	Mental/Behavioral health inpatient services	\$300 co-pay per admission	\$500 co-pay per admission/\$1250 maximum per calendar year	20% to max of \$2,000 per person per calendar year
	Substance use disorder outpatient services	\$15 co-pay	Subject to New York City non-participating benefit \$200/\$500 calendar year deductible	No lifetime maximum
	Substance use disorder inpatient services	\$300 co-pay per admission	\$500 co-pay per admission/\$1250 maximum per calendar year	----None----
If you are pregnant	Prenatal and postnatal care	No charge	0% co-insurance	----None----
	Delivery and all inpatient services	No charge	0% co-insurance	Enhanced schedule increases the reimbursement of the basic program's non-participating provider fee schedule, on average, by 75%.
If you need help recovering or have other special health needs	Home health care	No charge	\$50 deductible per episode; 20% co-insurance	200 visits per member per year. Pre-certification required.
	Rehabilitation services	\$15 co-pay	0% co-insurance	16 visits per calendar year
	Habilitation services	\$15 co-pay	0% co-insurance	----None----
	Skilled nursing care	Not covered	Not covered	Pre-certification required on greater than \$2,000
	Durable medical equipment	\$100 deductible	\$100 deductible; 50% of usual and customary charge	----None----
If your child needs dental or eye care	Hospice service	Not covered	Not covered	----None----
	Eye exam	Not covered	Not covered	----None----
	Glasses	Not covered	Not covered	----None----
	Dental check-up	Not covered	Not covered	----None----

Excluded Services & Other Covered Services:

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Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- | | | |
|--|--|---|
| <ul style="list-style-type: none"> • Acupuncture • Cosmetic surgery • Dental care | <ul style="list-style-type: none"> • Hearing aids • Long-term care | <ul style="list-style-type: none"> • Routine eye care • Routine foot care • Weight loss programs |
|--|--|---|

Benefits paid as a result of injuries caused by another party may need to be repaid to the health plan or paid for by another party under certain circumstances.

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- | | | |
|--|---|--|
| <ul style="list-style-type: none"> • Bariatric surgery • Chiropractic care | <ul style="list-style-type: none"> • Infertility treatment • Non-emergency care when traveling outside the U.S. | <ul style="list-style-type: none"> • Private-duty nursing |
|--|---|--|

Your Rights to Continue Coverage:

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Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact EmblemHealth.

All hospital grievances should be mailed to:

EmblemHealth-Hospital Grievance
 P.O. Box 2828
 New York, New York 10116-2828

All other grievances should be mailed to:

EmblemHealth-Grievance Unit
 P.O. Box 1701
 New York, New York 10023-9476

Oral Utilization Review Appeals can be initiated by calling toll

Or you may submit a written appeal to:
 EmblemHealth Utilization Review Appeals
 P.O. Box 2809
 New York, NY 10116-2809
 You may also obtain an external appeal application from:
 The New York State Department of Financial Services at 1-800-400-8882, or its
 Web site (www.dfs.ny.gov), or
 The EmblemHealth Medical/Utilization Review Department at 1-877-482-3625

Questions: Call **1-800-624-2414** or visit us at www.emblemhealth.com/sbc.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.emblemhealth.com/sbc or call **1-800-624-2414** to request a copy.



EmblemHealth® City of New York CBP w/ Opt. Rider

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 7/1/2013 - 6/30/2014

Coverage for: Individual/Family

Plan Type: PPO

free 888-906-7668.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-624-2414.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-624-2414.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-624-2414.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-624-2414

.....To see examples of how this plan might cover costs for a sample medical situation, see the next page.

Questions: Call **1-800-624-2414** or visit us at **www.emblemhealth.com/sbc**.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at **www.emblemhealth.com/sbc** or call **1-800-624-2414** to request a copy.

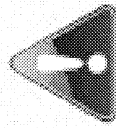


EmblemHealth® City of New York CBP w/ Opt. Rider Coverage Examples

Coverage Period: 7/1/2013 - 6/30/2014
Coverage for: Individual/Family | Plan Type: PPO

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



**This is
not a cost
estimator.**

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby (normal delivery)

- Amount owed to providers: \$7,540
- Plan pays \$7165
- Patient pays \$375

Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
Total	\$7,540

Patient pays:

Deductibles	\$150
Co-pays	\$75
Co-insurance	\$0
Limits or exclusions	\$150
Total	\$375

Note: These numbers assume the patient has given notice of her pregnancy to the plan. If you are pregnant and have not given notice of your pregnancy, your costs may be higher. For more information, please contact: 1-800-624-2414.

Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- Amount owed to providers: \$5,400
- Plan pays \$4675
- Patient pays \$725

Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
Total	\$5,400

Patient pays:

Deductibles	\$150
Co-pays	\$535
Co-insurance	\$0
Limits or exclusions	\$40
Total	\$725

Note: These numbers assume the patient is participating in our diabetes wellness program. If you have diabetes and do not participate in the wellness program, your costs may be higher. For more information about the diabetes wellness program, please contact: 1-800-624-2414.

Questions: Call **1-800-624-2414** or visit us at **www.emblemhealth.com/sbc**.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at **www.emblemhealth.com/sbc** or call **1-800-624-2414** to request a copy.



Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, co-payments, and co-insurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

- ✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

- ✗ **No.** Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

- ✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

- ✓ **Yes.** An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as co-payments, deductibles, and co-insurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.